ICF/MR LEVEL OF CARE EVALUATION

For use in applying for Home and Community Based Services
Alabama Department of MH/MR

Applicant Last Name_____ First Name _____ Date of Birth _____

Address: _____ City_____ Zip Code_____

County_____ Medicaid Number_____

Test Instrument Used for Psychological Evaluation _____ Date of Evaluation _____

Adaptive Functioning Instrument(s) Used (list all) _____

Date of ICAP Assessment _____ Date of most recent ICAP review _____

Submitting Case Manager Name: _____ Agency: _____

Intermediate Care Services are those services which are needed because of the severe, chronic nature of the mental impairment that results in substantial functional limitations in three (3) of the areas of life activity listed below.

This applicant is limited in three (3) or more of the areas of life activity listed below:

Indicate by placing an X in the appropriate box

☐ **Self Care** (ability to take care of basic life needs for food, hygiene and appearance).

☐ **Receptive and expressive language** (ability to both understand others and to express ideas or information to others either verbally or non-verbally).

☐ **Learning** (ability to acquire new behaviors, perceptions, and information and to apply experiences to new situations).

☐ **Mobility** (ability to ambulate or move from one location to another independently)

☐ **Self-direction** (managing one's social and personal life and ability to make decisions necessary to protect one's self).

☐ **Capacity for independent living** (age-appropriate ability to live without extraordinary assistance, to include maintaining adequate employment and financial support).

Mental Retardation Diagnosis Onset:

☐ Infancy
☐ Developmental (below age 18 years)
☐ Age 18 years and above

IQ Level	Adaptive Functioning Level
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Severe	☐ Severe
☐ Profound	☐ Profound

The applicant listed above is certified as meeting the ICF/MR level of care by DMH/MR:

APPROVED ☐ **NOT APPROVED** ☐

Signature_____Regional QMRP. Date:_____

Distribution: Original maintained in Regional Office. Copy returned to submitting provider.

10/06